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New Jersey Home Care Workforce Case Study: Final Report

Prepared for
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by
RTI International

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NEW JERSEY HOME CARE WORKFORCE CASE STUDY: FINAL REPORT

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EXECUTIVE SUMMARY

A direct care worker research and advocacy group recently ranked New Jersey number four of all 50 states and D.C. on a worker supportive policies index measuring states' adoption of recommended strategies to increase recruitment and retention of home care workers (PHI, 2023). The purpose of this case study is to describe New Jersey's experience and assess the effectiveness of these policies. Research methods included an environmental scan of published literature and Internet websites to identify worker supportive policy recommendations and to obtain information about state efforts in New Jersey and elsewhere to implement these policies. Given the lack of rigorous evaluation research, we also relied on qualitative interviews with 17 individuals knowledgeable about home care in New Jersey to solicit their views on the relative effectiveness of various worker supportive policies. Interviewees were selected to represent a range of stakeholder groups, including state officials (those involved not only with administering Medicaid-funded home care but also employment policies generally), home health/home care and other health care association representatives, managed care plan staff (enrollment of Medicaid recipients in managed care plans is mandatory in New Jersey), staff of private sector organizations that provide financial management, counseling, and support broker services to Medicaid program participants who "self-direct" their home care services, and several family caregivers who assist high need Medicaid home and community-based services (HCBS) users with intellectual and developmental disabilities in accessing self-directed and/or professionally managed services via their 1915 (c) Supports Waiver budgets.

This New Jersey case study provides insights into the daunting challenges states face in seeking to address the home care worker shortage, which has become more acute as New Jersey and other states have striven to "re-balance" Medicaid long-term services and supports (LTSS) use and spending away from institutional care toward HCBS. In a tight labor market, the key to overcoming the home care workforce shortage is to ensure that home care aide jobs can compete with other entry-level jobs and to expand the labor pool from which home care workers can be recruited to the extent possible.

Key Findings

Most home care worker advocates see improving home care aide compensation as the top priority. New Jersey is one of 23 states that have committed to raising the state minimum wage to $15 per hour, a goal that New Jersey will reach in 2024, after which it will be annually inflation-indexed. Whereas this policy has resulted in higher hourly wages for home care workers, it has also made it more difficult to guarantee them a favorable pay differential than other low-income jobs. New Jersey's main leverage over home care worker pay is the Medicaid rate it pays for agency-delivered and self-directed aide services. The New Jersey legislature has raised Medicaid rates for home care sufficient to enable employers to pay hourly wages that are a few dollars higher than minimum wage. However, employers seeking retail salesclerks, grocery store cashiers, restaurant, fast food, and hotel workers, etc. are also not limited to offering job seekers the minimum wage if justified by the revenues they make from being able to meet consumer demand. Also, very importantly, these employers are more likely to offer their workers full-time jobs, whereas a New Jersey survey (NJCCN, 2022) of certified homemaker/home health aides (CHHAs) found that fewer than half of these agency-employed aides work full-time. As a result, home care workers' annual earnings are likely to be less, even if their hourly wages are the same or higher than those of workers in other low-wage jobs.

Other challenges identified that relate to improving compensation include that part-time home care workers are unlikely to receive employer-sponsored health insurance, (as the Affordable Care Act does not require employers to offer such coverage to employees working fewer than 30 hours per week). Informants representing agencies. As a result, many they may seek Medicaid coverage or subsidized health insurance on the exchange. Informants representing agency employers noted that agencies face challenges addressing worker shortages by offering overtime work opportunities because both Medicaid and the hourly rates private payers are willing to pay are insufficient to cover overtime pay. Many home care workers rely on means-tested

government benefits to supplement their low incomes. State officials noted that if the state raises direct care worker wages those who rely on these programs may lose coverage due to “benefit cliffs” that threaten the ability of low-income home care aides to cover basic living costs for themselves and their families. This occurs when pay increases make home care workers ineligible for public programs, such as Medicaid insurance coverage or Supplemental Nutrition Assistance Program, but are not sufficient to make up for the loss of such benefits. However, New Jersey and other states may have little ability to address benefit cliffs insofar as the Federal Government sets means-tested eligibility thresholds for public programs that are solely federally funded and even where some state discretion exists, it is constrained by federal law and regulations.

The main advantage that home care has over other low-income jobs is that it attracts individuals who are strongly motivated by the desire to help other people. However, home care aide work has several comparative disadvantages relative to other low-income jobs that are difficult for states to address via Medicaid or other state policies alone. These include higher than average health risks both from infectious diseases (the number of CHHAs in New Jersey decreased by 16.5% during the COVID-19 pandemic according to the 2022 New Jersey Collaborating Center for Nursing [NJCCN] survey) and the high rate of occupational injuries attributable to the physical strain of providing manual assistance with personal care tasks that involve lifting and positioning home care recipients.

In addition, New Jersey has higher than average pre-employment training/credentialing and criminal background check requirements for agency-employed aides compared to other states. Other entry-level jobs offer free, on-the-job training, whereas many applicants for agency aide jobs are required to cover the costs of their training, competency testing, and credentialing application fees (an Internet search found costs ranging from $450 to $1,000), although agencies that hire them may subsequently reimburse those costs over time by paying retention bonuses. Interviewees expressed concern that the training, testing, credentialing process for CHHAs is too lengthy. Applicants who cannot afford the wait take other jobs where they can be hired and begin earning income immediately. Home care workers’ opportunities for promotion with higher pay are scarce.

Interviewees also pointed out that home care workers serving suburban and rural areas typically lack access to reliable, timely public transportation. Since their worksites are clients’ homes and assignments and schedules may change, they are more likely than workers in grocery and retail sales stores and in the food service and lodging industries to need to be able to buy and maintain a car.

New Jersey has sought to partner with business and industry groups as well as with academic institutions and philanthropies to address aspects of home care aide jobs that make them less competitive and require creative initiatives that go beyond state Medicaid reimbursement rate-setting policies. Thus far, however, these efforts have had mixed success. In the late 1990s, New Jersey received Robert Wood Johnson Foundation funding to participate in the Cash & Counseling Demonstration and Evaluation, a randomized controlled trial pilot project in three states that tested a new model of consumer (self)-directed services. The Personal Preference Program serving elderly and younger physically disabled individuals eligible for Medicaid state plan-covered personal care services (PCS) transitioned from an experiment to become an option regularly available to all individuals eligible for the PCS benefit in 2008. Subsequently, New Jersey added self-directed services options to 1915(c) HCBS waiver coverage for individuals with intellectual and developmental disabilities. Take up of self-directed services has since grown greatly. This helps mitigate the home care worker shortage because self-directing program participants are not required to receive personal care assistant services via agencies; they are permitted to recruit individuals who may be family members, friends, and relatives who would not have applied to become agency-employed CHHAs.

Other grant-funded initiatives have been less successful. For example, over a decade ago, New Jersey received Robert Wood Johnson Foundation funding for a demonstration program, authorized by the State Board of

Nursing (SBON), to experiment with nurse delegation. Licensed nurses could train and delegate routine skilled nursing tasks -- in particular, administration of prescription medications -- to agency aides. Individual providers employed by self-directing program participants were already allowed to administer prescription medications and specially trained and credentialed medication aides already existed in nursing homes and assisted living facilities. The state Medicaid agency offered agencies that agreed to participate in the demonstration enhanced Medicaid reimbursement for nurse delegation. Although state officials and a Rutgers University evaluation judged the experiment a success, nurse delegation did not continue after the demonstration ended even though the Board of Nursing changed the Nurse Practice Act to explicitly authorize it. The reason nurse delegation in agencies failed to take hold, according to our interviewees, is due primarily to resistance on the part of agency-employed nurses and the need for additional financial incentives beyond the enhanced Medicaid rate. At the same time, some interviewees representing the home health/home care industry said they were unaware of the enhanced Medicaid funding.

Recently, the New Jersey state employment agency partnered with business and industry groups to launch a home care aide recruitment campaign stressing the social value of home care aide work. However, the campaign's first job fair was poorly attended.

1. BACKGROUND

Direct care workers (DCWs) such as home care aides and personal care assistants (PCAs) play an essential role in the health and well-being of millions of Americans who receive LTSS. DCWs help older adults and people with disabilities from physical, cognitive, developmental, and behavioral conditions complete daily tasks and self-care activities. In 2020, 2.4 million DCWs provided care in people's homes and 675,000 worked in residential care settings like group homes and assisted living facilities (Campbell et al., 2021).

Between 2009 and 2019, the direct care workforce grew from 3 million to 4.6 million in reaction to an aging population and an increase in people living longer with disabilities and chronic conditions (Campbell et al., 2021). The sector is projected to add more new jobs than any other occupation in the United States between 2019 and 2029 (PHI, 2021).

However, this increase in workers has not yet met the demand, which is being fueled in large part by state efforts to "re-balance" Medicaid LTSS use and expenditures away from institutional care toward HCBS. A recent study found that nationally the home care workforce grew from 840,000 to 1.42 million from 2008 to 2019. Simultaneously, the number of people participating in Medicaid HCBS programs increased even more rapidly. As a result, the number of home care workers per 100 Medicaid HCBS participants decreased by 11.6% from 2013-2019, suggesting that the need for home care workers outstripped the supply (Kreider & Werner, 2023).

Longstanding workforce shortages and frequent turnover in the LTSS sector have been directly linked to low wages and poor quality of care (Ghandi et al., 2019). These shortages have been exacerbated by the COVID-19 pandemic (PHI, 2022). DCWs receive poor pay, rarely receive benefits, and experience high injury rates (Institute of Medicine, 2008). In 2020, home health and personal care aides had a national median pay of $13.02 per hour, or $27,080 per year, and an estimated 46% of LTSS workers used Medicaid for health insurance in 2017 (U.S. Bureau of Labor Statistics, n.d.; Oh, 2017). A recent study modeling the effects of higher pay for DCWs noted that raising wages would enhance financial security and reduce reliance on public programs, reduce turnover and labor shortages, improve productivity, and provide a boost to the economy (Weller et al., 2020).

States have implemented numerous measures to address these low wages. In response to the public health emergency (PHE), several states took temporary steps to provide hazard pay, bonuses, and other wage enhancements through funds authorized by the Coronavirus Aid, Relief, and Economic Security Act (Denny-Brown et al., 2020; Weller et al., 2020). Anecdotal evidence from providers suggests these temporary payment increases enhanced the ability of LTSS providers to retain existing workers and recruit new staff (Denny-Brown et al., 2020).

1.1. Rationale for New Jersey Case Study

New Jersey was selected for this case study because of the state's efforts to increase the availability of HCBS and to improve home care worker recruitment and retention. PHI (2023) recently scored New Jersey in the top tier with respect to state policies for direct care workforce supports, based on 2021 data. Compared to other states, New Jersey does not have the most serious reported worker shortage, likely because worker shortages tend to be greatest in states with sizable rural areas, whereas New Jersey has few (Chapman et al., 2022). Nevertheless, according to one study (Marchese, 2023), New Jersey is in the next to lowest quintile with respect to the ratio of DCWs to the state's population. A survey of CHHAs in New Jersey found a sizable drop of 16.5% in the number of such workers from 2017/2018 to 2020/2021 (NJCCN, 2022), indicating that the number of DCWs having the credentials necessary to be employed by home health/home care agencies in New Jersey was adversely affected by the COVID-19 pandemic.

According to PHI, New Jersey has a higher-than-average rate of reliance on foreign born workers, who are either naturalized citizens or green card holders, to fill DCW jobs (53%). Given current United States immigration policies, this high reliance on immigrant workers could pose a growing challenge for the state in future years. According to the New Jersey Collaborative Center for Nursing survey of CHHAs, 29% reported speaking a language other than English at home and 19% reported a lack of English-speaking proficiency (NJCCN, 2022).

1.2. Case Study Purpose and Research Questions

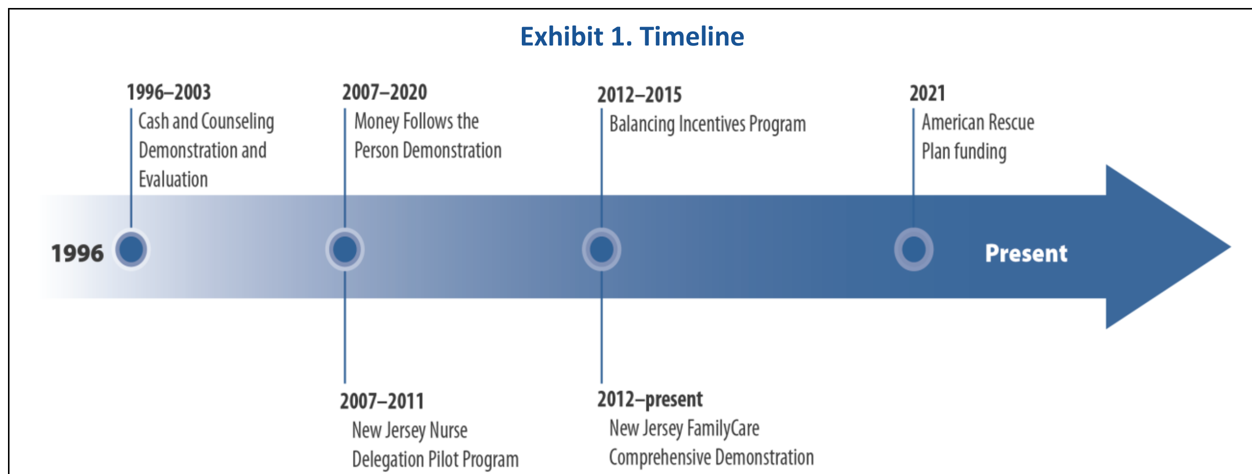
The purpose of this in-depth case study of New Jersey's efforts to address worker shortages is to answer the following research questions:

1. What factors exacerbate or mitigate the challenges of home care worker recruitment and retention in New Jersey?
2. What strategies has New Jersey adopted to improve home care worker recruitment and retention? Which of these strategies have been more-or-less effective?

1.3. TimeLine of New Jersey's Efforts to "Re-Balance" Toward HCBS and Adopt Innovative Modes of Service Delivery

Like many states, New Jersey has made efforts to re-balance their spending away from institutionalized care and toward HCBS, which requires maintaining existing staff and increasing the supply of home care workers (Murray et al., 2021; Christ & Sherman-Greenup, 2022). As shown in ***Exhibit 1***, New Jersey has, since the early 1990s, expanded Medicaid HCBS coverage under 1915(c) waivers and the optional state plan PCS benefit, and participated in several demonstration projects and other grant-funded initiatives affecting the provision of HCBS and, therefore, the home care workforce.

Exhibit 1. Timeline



1.4. New Jersey's Use of Medicaid Funding Authorities for HCBS

By the mid-1990s, New Jersey was providing HCBS PCS through an optional state plan benefit and 1915(c) waivers (LeBlanc, Tonner & Harrington, 2001). However, Medicaid spending on LTSS was still heavily oriented toward institutional care. The state plan PCS benefit is an entitlement; that is, all who qualify must be served, whereas "c" waivers may cap enrollees and maintain waiting lists. PCS benefit recipients must require assistance with at least one personal care task but, unlike waiver recipients, they need not meet nursing home level of care coverage criteria. However, access to state plan PCS is more strictly means-tested. Despite considerable growth in state plan PCS and HCBS waiver enrollees since 1996, there are currently 2,200 individuals with intellectual and developmental disabilities in New Jersey on waiting lists for individuals with

developmental disabilities (IDD) waiver services (Stanton, 2023). While on HCBS waiver waiting lists, they may receive state plan home health care services and/or state plan PCS if they qualify for such coverage.

1.5. Cash & Counseling Demonstration and Evaluation

In 1996, New Jersey became one of three states chosen to participate in the experimental Cash & Counseling Demonstration and Evaluation (CCDE) sponsored by the Robert Wood Johnson Foundation and U.S. Department of Health and Human Services, which was created to test a new model of consumer directed HCBS. Individuals in New Jersey who were eligible to receive state plan PCS could volunteer to be randomized to the treatment or control group. Control group members could only receive agency-delivered personal care aide services, whereas treatment group members could access a "budget" and exercise more choice and control over their Medicaid-funded home care by using their funds to purchase a range of disability-related goods and services. These included employing individual aides whom they recruited and could hire/fire, schedule, and supervise rather than receiving assistance from agency-employed aides (Mahoney & Simone, 2000). They could employ family members (including spouses in New Jersey), friends, or neighbors and could negotiate hourly pay rates with their aides so long as they paid them at least minimum wage New Jersey's CCDE, which the state named the Personal Preference Program (PPP), launched in 1999 (Mahoney & Simone, 2000; Brown et al., 2007). The randomized controlled trial evaluation found that treatment group members had better outcomes on a range of measures including reductions in reports of unmet need for help with personal care tasks, greater satisfaction with the quality of aide services and quality of life on the part of service recipients, fewer adverse health events such as bedsores, and lower reports of stress and burden from family caregivers. There were no outcome measures on which control group members scored higher. The positive evaluation results from the CCDE in all three states prompted Congress and the Centers for Medicare & Medicaid Services (CMS) to change Medicaid law and regulations to enable all states to adopt this model of self-directed services if they chose to do so. New Jersey received an approved 1915(j) state plan amendment shortly after this provision became available under the 2005 Deficit Reduction Act, which allowed New Jersey's PPP to transition from an experiment with capped, time-limited enrollment to a regular feature of the state's Medicaid plan funded via the optional state plan PCS benefit. Applied Self-Direction (2020) reported that the number of Medicaid recipients self-directing their PCS increased from 2,587 in 2011 to 18,559 in 2019.

1.6. New Jersey's Participation in the Balancing Incentive Program

In addition, New Jersey participated in the federal Balancing Incentive Program (BIP) from 2012 through 2015. During this time, New Jersey made considerable progress in re-balancing Medicaid LTSS spending away from institutional care toward HCBS, falling just short of the 50% spending goal at the end of the program in 2015 (Karon et al., 2019). As of 2019, New Jersey's 47.5% spending on HCBS still fell short of the 50% or greater BIP goal (MPR, 2022). Concomitantly, the number of Medicaid LTSS users in the state receiving HCBS rose from 29% in 2014 to 61% as of 2019 (Christ & Sherman-Greenup, 2022).

Part of New Jersey's efforts to re-balance toward HCBS included overhauling the mandatory managed care program known as managed LTSS (MLTSS) (introduced in 2013) into a unified program (Mission Analytics Group, 2017). The unified MLTSS program is called the New Jersey Family Care Comprehensive Demonstration (NJ FamilyCare, n.d.) and it brings together six Medicaid waiver programs (NJ DMAHS, 2021). Those who are eligible for NJ FamilyCare can enroll in one of five managed care organizations (MCOs) (NJ FamilyCare, n.d.). Enrollment in the MCOs began in 2014 (Mission Analytics Group, 2015). People who qualify for personal care assistance as part of their NJ FamilyCare Plan may enroll in the PPP, which gives enrollees the ability to hire family, friends, or others as PCAs (NJ DHS, n.d.). CMS enabled states to pay legally responsible relatives as personal assistance services (PAS) providers under Section 1915(j) state plan amendments beginning in 2008 and New Jersey sought and obtained 1915(j) authority to allow PPP aide payments to spouses of disabled adults. However, prior to the COVID-19 pandemic, the New Jersey state agency responsible for administering services to people with IDD did not allow such payments to parents/legal guardians. The agency then

requested CMS amend New Jersey's HCBS IDD waiver to temporarily remove the prohibition on paying legally responsible relatives for care. During the pandemic, other states also suspended such restrictions on paying "legally responsible" relatives including spouses as well as parents of minor children and legal guardians of adults enabling them to receive payments to assist their relative rather than provide the service unpaid, thus expanding the PAS and the home care workforce (Iezzoni et al., 2019). New Jersey has now requested and obtained permission to make allowing parents, spouses, guardians and other "legally responsible" family members to become paid caregivers permanent, so long as they are not also serving as designated "representatives" to help self-directing program participants manage their individual budgets and employees.

1.7. Home Health/Home Care Agency Nurse Delegation Demonstration

New Jersey's Nurse Practice Act has long contained exemptions for family members and "domestic employees" providing home care. Because workers employed directly by PPP participants are all considered domestic employees and are also often family members, PPP participants and their designated representatives can train or arrange for their workers to be trained to perform routine skilled nursing tasks without violating the Nurse Practice Act. Additionally, several years ago, New Jersey officials succeeded in persuading the New Jersey Board of Nursing to explicitly allow home care agency nurses to delegate some skilled nursing tasks -- medication administration, in particular -- to agency aides by providing appropriate training and ongoing nurse supervision. Earlier, under a 2011 Nurse Delegation Demonstration Project sponsored by the Robert Wood Johnson Foundation, New Jersey sought to create a potential career ladder for agency-employed home care aides via an enhanced Medicaid payment for agencies for cases involving CHHA performance of nurse delegated tasks (Rutgers Center for State Health Policy, 2011). Results from this demonstration are described in ***Section 3.2.5***.

1.8. Mandatory Managed Long-Term Services and Supports

Since 2013, most Medicaid LTSS in New Jersey, including the PPP, has been funded through a Medicaid 1115 waiver as part of New Jersey's Family Care Demonstration which requires Medicaid long-term care recipients to enroll in one of five managed care plans. The exception is 1915(c) HCBS waiver services for persons with developmental disabilities funded under the Community Care Waiver and the Developmental Disabilities Supports Waiver, which, since 2017, have operated on a fee-for-service basis and are administered by the state Developmental Disabilities agency (NJ DHS/DDD, 2021).

1.9. Money-Follows the Person

I Choose Home -- New Jersey's federally-funded Money Follows the Person (MFP) program -- launched in 2008 and helps people who have been in an institution for 60 or more days and are eligible for Medicaid return to a community setting (NJ DHS/DDS, n.d.). These efforts are focused on older adults, people with disabilities, and people with mental illness. A 2014 report by the federal MFP evaluation contractor credited New Jersey with having transitioned 1,244 individuals (42% with IDD) from institutional LTC settings to community living. *I Choose Home* is still in existence in New Jersey as part of its MLTSS.

2. METHODS

For this case study, RTI conducted an environmental scan of peer-reviewed and grey literature to understand what strategies have been recommended to improve home care worker recruitment and retention, and which of these strategies have been tried in New Jersey. We also conducted interviews with 17 stakeholders in New Jersey. The purpose of these interviews was to understand how policies implemented in New Jersey have helped or hindered home care workforce recruitment and retention.

2.1. Environmental Scan

We first identified grey literature sources including websites of industry groups, advocacy groups, and the federal government, as well as the New Jersey Department of Human Services (NJ DHS) and Department of Labor websites. Key search terms included the various terms used for DCWs and terms such as "retention," "recruitment," and "self-direction." We identified 180 sources and systematically reviewed them for relevance. We abstracted the home care worker recruitment and retention recommendations included in these sources into the following categories: compensation, benefits, leave, wage pass-through (WPT), wage floor, delegation, career ladder, Medicaid policy, and other. Sources specific to New Jersey were abstracted for more detailed information related to our research questions. Data were organized in a data tracker and formatted as a sortable Excel spreadsheet.

An experienced librarian also conducted searches of peer-reviewed articles published after 2012 that included our key search terms. The librarian provided the research team with over 200 article abstracts. Abstracts were reviewed for relevance and 35 articles were included in the full text review. Information extracted from each article was organized into the same categories applied to grey literature. Seminal research from before 2012 is also cited in this report when relevant.

We also obtained information, including New Jersey-specific information, from a wide variety of other Internet websites; for example, information on hourly wages from various New Jersey CHHA agencies seeking staff were obtained from online job posting sites such as Indeed.com and ZipRecruiter.com.

2.2. Stakeholder Interviews

RTI conducted interviews with 17 stakeholders in New Jersey, including state officials, MLTSS MCO executives, health care association executives, financial management service providers, service recipients, and academics with expertise in the direct care workforce. We developed interview protocols tailored to each type of stakeholder based on our environmental scan findings and the project research questions. Interviews were recorded with the participants' permission and transcribed and summarized, and key themes were identified.

3. FINDINGS

The purpose of this case study was to identify strategies recommended by advocacy organizations, industry groups, researchers, and others to improve recruitment and retention of home care workers and PCAs. We also sought to determine which strategies New Jersey has used. Stakeholders reported on which strategies for improving home care worker recruitment and retention have been most successful in New Jersey, which have been less successful, and what more the state can do to mitigate worker shortages.

3.1. Recommended Strategies for Improving Recruitment and Retention

Our environmental scan identified several common strategies for improving worker recruitment and retention, including:

- Increasing compensation.
- Incentivizing high-quality care.
- Providing employment benefits.
- Improving training standards and opportunities.
- Establishing a "universal worker" category.
- Developing career ladders.
- Implementing expanded roles and responsibilities through nurse delegation.
- Creating worker registries.
- Increasing the pipeline of available workers by developing creative approaches to recruitment, including partnerships between state government, business and industry groups, philanthropic organizations and academia.
- Collecting data on the workforce to measure outcomes.
- Implementing cross cutting programs.

These recommended strategies are detailed below.

3.1.1. Increase Compensation

Increasing compensation is a common recommendation for improving recruitment and retention of home care workers (Weller et al., 2022; Reinhard et al., 2021). This can be operationalized in several ways; two of the most common approaches are WPT and wage floor policies.

WPTs occur when states increase Medicaid reimbursement rates to providers with the stipulation that these increases be passed on to DCWs. There are three main ways that states implement WPTs: (1) requiring a certain dollar amount be added to the wages or benefits of DCWs; (2) requiring a certain percentage of the Medicaid reimbursement rate providers receive be used to compensate DCWs; and (3) creating state trust funds that can be used to increase worker wages (Yearby et al., 2020). A recent study found that 22 states and the District of Columbia have used WPTs to increase compensation for various types of DCWs since 2009 (Tyler et al., forthcoming).

Wage floor policies are also known as minimum wage policies. Wage floors have been used by states to set minimum wage policies for different types of DCWs. A recent study found that seven states had implemented such a policy (Tyler et al., forthcoming). An increasing number of states are also implementing minimum wage and living wage policies for all state workers. The U.S. Department of Labor established a final rule extending the application of the minimum wage and overtime regulations under the Fair Labor and Standards Act to DCWs providing services in the home setting in October 2015 (Morgan, 2016). This rule meant that all home care aides must be paid the federal minimum wage and overtime, with a few exceptions.

As a result of the PHE, new compensation strategies were used to address issues in home care worker compensation. One early review of state policy changes affecting home care workers found that 21 states had increased payment rates for agencies or providers. Nineteen states implemented hazard pay or "add-on" hourly payments that increased the workers' hourly wages. For example, Connecticut established the "Connecticut Premium Pay program" to provide $200-$1,000 to essential workers who were providing health care services throughout the pandemic. Similarly, New York announced $1.2 billion for the Worker Bonus Program aimed at rewarding and retaining frontline health care workers, paying up to $3,000 in bonuses to aides and other qualifying staff (Abbasi, 2022). Although some of these increases were one-time and may not be as not as impactful as permanent wage increases, they signal to DCWs that they are valued by the state and have the potential to improve DCW morale (Milbank Memorial Fund, n.d.). Federal guidance for use of American Rescue Plan (ARP) Act funds also included using funds to increase home care worker wages (CMS, 2021).

3.1.2. Encourage Self-Direction to Increase the Size of the Home Care Labor Pool

In addition to using WPT policies to increase compensation, other Medicaid policy changes may improve home care worker recruitment and retention. One such policy is self-directed care, which allows consumers to recruit, hire, and train home care workers. Almost all states allow self-directing service recipients to directly hire family, friends, and neighbors, although some impose restrictions on the types of kin that may be hired. The ability to hire family, friends, and neighbors increases the available pool of workers insofar as they would not have sought employment via a home care agency. Many are only interested in aiding relatives or persons they know well and perhaps live with or near to. Part-time work according to schedules they can control may also be an attractive feature. This expansion beyond agency-employed aides can also be helpful for the beneficiary and the state because many self-directing program participants select caregivers who are culturally congruent and speak the language they speak (MACPAC, 2022). In addition, family members may be well suited to provide nurse delegated tasks because of the close relationships and continuity of care characteristics of self-directed services. These workers may be able to obtain training in the tasks consumers require and be allowed to provide skilled nursing services because most state Nurse Practice Acts provide "exemptions" that permit licensed nurses to train family members to perform routine skilled tasks without the nurses being held subsequently responsible for providing ongoing supervision of family members' performance of those tasks (Reinhard, 2001).

Self-direction gives the consumer choice (Ko et al., 2020), and has the potential to offset DCW worker shortages particularly in rural areas (Chapman et al., 2022). States can implement self-direction under any of the Medicaid state plan or waiver statutory authorities they use to fund HCBS (CMS, n.d.). However, restrictions may apply under some authorities. For example, states cannot choose to pay "legally responsible" relatives (i.e., spouses, parents of minor children, legal guardians) under the traditional state plan PCS benefit unless they also obtain an approved 1915(j) state plan amendment. Although federal Medicaid law allows states to pay any family members, states retain discretionary authority to decide whether or which categories of kin may be hired by self-directing HCBS recipients and they need to notify CMS of their decisions in their HCBS waiver initial, renewal, and amended waiver applications.

Increased Federal Medical Assistance Percentages (FMAP) funds, available through the ARP Act, can also be used to provide reimbursement to family caregivers. Three states (Arizona, Minnesota, and Illinois) have proposed using these funds to enhance access to HCBS by providing reimbursement specifically for family caregivers of children (Teshale & Fox-Grage, 2022). The National Strategy stemming from the RAISE Act recommends continued CMS support for states that want to pay family caregivers (RAISE Act Family Caregiving Advisory Council & Advisory Council to Support Grandparents Raising Grandchildren, 2022).

Federal guidance also supports increasing the wages of workers in self-directed care programs. Guidance suggests that states provide hazard pay, overtime pay, and shift differential pay for direct support professionals (DSPs) (CMS, 2021). One study found high satisfaction levels among 45% of directly hired workers across three states even though they received modest (and sometimes late) pay and almost no fringe benefits (MPR, 2005). Consumers can sometimes drive higher pay rates for self-directed staff because they can pay a higher hourly wage or purchase more hours of care than workers may receive from agencies. For example, directly hired workers in Florida and New Jersey were paid about $1 an hour more than agency hired DCWs in their states during the CCDE (MPR, 2005). However, whether self-directing program participants exercising budget authority can afford to pay the same or higher wages than agency-employed aides are paid depends on how states choose to calculate self-directed services budgets relative to agency reimbursement rates as well as the extent to which periodic reimbursement rate increases for agencies are also applied to the calculation of self-directed services budgets. Currently, based on 2023 New Jersey wage information available for agency and PPP aides posted on Indeed.com, it appears that average PPP aide wages are no longer higher than agency aide wages.

One downside to self-direction is that workers in self-directed care programs generally lack the employment benefits discussed in ***Section 3.1.4***. Some advocates recommend that states ensure mechanisms are in place for supporting these workers and facilitating their access to benefits such as health insurance and retirement accounts (PHI, 2019).

3.1.3. Incentivize High Quality Care that Improves the Workforce

States can also use value-based purchasing (VBP) methodologies as part of their Medicaid reimbursement system to improve recruitment and retention of workers. For example, in 2015, Minnesota implemented a value-based reimbursement system where care-related costs, such as nursing wages, are reimbursed at actual costs subject to a quality limit. Though the system was not designed specifically to improve wages and benefits for DCWs, early reporting by facilities suggested that it did so (MN DHS, 2017). This system was used in nursing facilities but could be applied similarly in HCBS. Medicaid reimbursement strategies could also be used to incentivize HCBS providers to provide more training and development opportunities to their workers (Spetz et al., 2019). More work is needed to develop a core set of workforce quality measures to set standards and incentivize quality improvement in care. Quality measures could address compensation, training, turnover, job vacancies, and other issues.

3.1.4. Provide Employment Benefits (e.g., health insurance, sick leave, paid family leave)

Providing benefits to home care workers is another commonly recommended strategy for improving recruitment and retention. Benefits such as health insurance and paid leave can help to boost workers' overall compensation (PHI, 2021c). These benefits create a safety net for workers (Milbank Memorial Fund, n.d.) and increase their quality of life. According to the literature, the provision of paid medical and family leave is essential to retain workers (PHI, n.d.-b; Reinhard et al., 2021; Eldercare Workforce Alliance, n.d.; Franzosa et al., 2019). Without these types of paid leave, workers must choose between their health and loss of income. Without paid leave, workers also lack access to needed recovery time and respite (Reinhard et al., 2021).

States can incentivize or mandate the provision of critical employment benefits for DCWs, such as affordable health insurance or paid leave (Scales, 2022; Milbank Memorial Fund, n.d.). Though not mandated, the Oregon Essential Workforce Health Care Program provides supplemental payments to long-term care facilities, residential facilities, and home care agencies that elect to participate and provide health care benefits to employees (Bill Track *50*, 2021). States were also given the option to use temporary ARP Act funds to increase benefits that were not included in typical HCBS rate settings for agencies employing DCWs (CMS, 2021).

Other types of leave recommended for home care workers include paid vacation leave (Milbank Memorial Fund, n.d.; PHI, 2021; Franzosa et al., 2019) and bereavement leave (PHI, n.d.-b; Franzosa et al., 2019). Benefits outside of leave that are recommended include other wraparound benefits such as assets development programs (PHI, n.d.-b), childcare (National Skills Coalition & Business Leaders United, n.d.), and mental health or counseling services (Franzosa et al., 2019). Some states have offered childcare vouchers or subsidies so DCWs are able to consistently access and afford safe and reliable childcare (Milbank Memorial Fund, n.d.).

It is possible for individual providers hired by self-directing Medicaid participants to receive fringe benefits in addition to wages. In some states such as California and Washington State, where consumer-directed workers are represented by labor unions in collective bargaining over Medicaid-funded aide compensation, benefits such as health insurance coverage, paid time off, public transportation subsidies, and retirement funds have been gained through contract negotiations. In California, contracts are negotiated county by county, with the result that benefits available to individual providers of consumer-directed In-Home Supportive Services vary across counties. In Washington State, Service Employees International Union 775 contract negotiations regarding pay and benefits cover all self-directed and agency-employed aides.

3.1.5. Improve Training Standards

Improving training for home care workers is another recommended strategy as these workers often receive little to no training (PHI, n.d.-b; PHI, n.d.-c). Suggested training topics include: communication, infection control and prevention, person-centered practices, and safety and emergencies (Bryant et al., 2021; PHI, 2021b). Improvements in training for this workforce could reduce worker injuries and improve quality of care (PHI, n.d.-b; PHI, n.d.-c). In 2016, injury rates for DCWs were among the highest of all occupations in the United States (Campbell, 2018; Reinhard et al., 2021). Training may also provide new opportunities for home care workers in terms of their professional growth, potentially leading to increased job satisfaction and higher worker retention (Jumabhoy et al., 2022). Credentialing (i.e., training that leads to a certification or license) has been shown to be related to higher likelihoods of full-time work, year-round work, having access to employer-provided health insurance and retirement saving plans, and earning more annually, but these effects are reportedly small and may not translate to improved recruitment or retention (Kim, 2020).

Another recommendation is to standardize national training requirements (Long-Term Care Commission, 2013; LeadingAge, 2021d; PHI, 2021b). Federal statute requires a minimum of 75 hours of training for Medicare-Medicaid certified home health aides but not for home care aides or PCAs. The 2008 Institute of Medicine report on the future of the direct care workforce recommended the implementation of federal training standards for home care workers across all settings and the introduction of required training hours for PCAs, but there has been little progress toward adopting this recommendation (Spetz et al., 2019). Seven states do not have any training requirements for PCAs, and only 14 states have uniform training standards for all agency-employed PCAs (PHI, 2019).

While some federal guidance is available, worker advocates still call for better standardization of these requirements at the federal and state levels (Reinhard et al., 2021). More recently, recommendations stemming from the RAISE Family Caregiver Act have called for grants to support education and training of home care workers (RAISE Act Family Caregiving Advisory Council & Advisory Council to Support Grandparents Raising Grandchildren, 2022). Some advocates see Washington State as an exemplar that other states should follow. Washington requires a minimum of 75 hours of training and a competency assessment (i.e., test) for PCAs and 12 hours of continuing education per year. Training and credentialing are mandatory for both agency-employed aides and most of those employed by self-directing program participants (the latter account for the majority of PCAs). Aides have up to four months after beginning work to complete the training and pass the credentialing exam. This training/testing (available in languages other than English) is gratis (although fees for testing are waived only if applicants pass the exam on their first try). However, periodic audits of the

Washington program have found significant barriers to training completion. For example, a lack of testing locations has led to greater wait times for testing and longer travel distances to testing locations resulting in fewer potential home care workers completing the program. Overall, some 40% of those who start training either never complete it or fail to pass the credentialing exam or, even if they are successful do not choose to work as home care aides. Because most of the attrition was among foreign born individual providers, including family members, Washington decided to reduce the training/credentialing requirements for parents and adult children of care recipients and for individual providers who are employed relatively infrequently as respite or back-up workers when regular workers are unavailable (Washington State Auditor, 2022).

Some states require basic competency-based training content (i.e., first aid or CPR) for workers in self-directed programs, but additional training is often needed to address the beneficiary's own needs and preferences (NADSP, 2016). Directly hired workers do not typically receive training comparable to that of their agency counterparts. In most states, at least 95% of agency workers who provide routine health care received such training (MPR, 2005).

Some advocates for worker training have recommended that states adopt updated training requirements for home care workers (Scales, 2022; Milbank Memorial Fund, n.d.) to ensure that workers are adequately prepared for their roles and to facilitate career mobility and workforce flexibility (Scales, 2022). As part of the standardization of federal and state training requirements, worker advocates suggest that training curricula need to reflect the full set of complex skills needed for this work. Updates are needed especially because most trainings have not been updated for some years and the acuity level and needs of LTSS consumers have changed significantly (PHI, n.d.). It has also been suggested that training would increase consumer confidence in this workforce (LeadingAge, 2021). However, others suggest that directly hired workers do not need the same training as agency hired workers because they have different characteristics and experience with the consumer (e.g., they may be related to the consumer). Directly hired workers may instead benefit from in-depth, customized training relevant to the consumer's specific needs (National Resource Center for Participant-Directed Services, 2009).

3.1.6. Improve Training Opportunities by Eliminating Out-of-Pocket Costs to Workers

One concern that has arisen from studies of mandatory training requirements is that applicants for home care aide jobs may have to pay for their training. LeadingAge (2021e) recommended that states ensure accessibility to training by adopting policies that provide funding for it and suggested several different strategies for doing so. Because training requirements and the costs associated with these may create a barrier to entry into direct care work, another commonly recommended strategy is to increase funding for worker training. The costs associated with training DCWs are not directly reimbursable (that is, as labor costs rather than the administrative overhead component of reimbursement) through Medicaid or Medicare, which places the funding burden on individual workers, employers, or third-party training entities. This may undermine access to training programs and/or compromise their quality (PHI, 2021b). This may also undermine access to direct care jobs for those who cannot afford out-of-pocket costs, even if later reimbursed. States can build partnerships with industry to provide improved training opportunities. For example, Tennessee formed a public-private partnership through the Direct Support Professionals Apprenticeship Program to address workforce shortages. The program compensates individuals for on-the-job training and increases wages by $3.50 per hour upon completion of the program (NCSL, 2022).

Providing stipends can encourage worker participation in training and states can offer stipends tied to training. These funds can be used to: (1) provide a cash stipend to workers who complete in-service or other trainings; (2) provide stipends to more experienced workers who provide training to new employees; and/or (3) provide stipends, paid time off, or other reimbursement (e.g., textbook funds) for employees who want to become licensed or credentialed at a higher level (Spetz et al., 2019; Milbank Memorial Fund, n.d.). Some advocates

supported fully authorizing the American Jobs Plan which would have expanded federal financial aid to high-quality, short-term training programs. These programs would help workers rapidly upskill for new or higher-level positions (National Skills Coalition & Business Leaders United, n.d.). Increasing grant opportunities, at the federal or state level, is also recommended to provide greater access to training opportunities. The costs of worker training can also be reduced -- as well as made much more convenient for job applicants who cannot work and be paid before training has been completed -- if all or most training can be obtained on-line rather than via attending in-person classes.

3.1.7. Establish a "Universal Worker" Category to Better Meet Workforce Needs Across Settings and States

Some recommend establishing training requirements for "universal workers" who could master and demonstrate a core set of competency-based training standards identified by federal policymakers. These "universal workers" would then have the flexibility to work across settings and even across state boundaries, responding to caregiver shortages in specific markets (LeadingAge, 2021). Training and credentialing increase the ability for workers' skills to be transferrable across state lines. Use of a competency-based credentialing system would provide workers with a recognized, portable indicator of the breadth and depth of their knowledge, training, and expertise. Ensuring that credentials are portable across care settings would enable capacity and flexibility, especially when systems are strained (Milbank Memorial Fund, n.d.) However, a potential downside is that if all LTSS DCWs must participate in a universal training/credentialing process, settings that tend to pay more and offer more full-time and overtime hours (e.g., Medicare/Medicaid certified home health agencies and hospices, nursing homes, and assisted living facilities) could have a competitive advantage in attracting workers vis-a-vis home care agencies that provide personal care and homemaker services.

3.1.8. Develop Career Ladders to Promote Career Growth and Advancement

Career ladders are a good way to provide structure and equitable opportunities to home care workers (Osterman, 2017; LeadingAge, 2022). Career ladders are meant to encourage upward mobility and growth into meaningful LTSS careers allowing home care staff to grow into advance caregiving roles and to feel valued as team members (LeadingAge, 2021). Research has shown that advancement opportunities such as developing skills and pathways for professional growth are negatively correlated with intent to leave the home care job; however, home care staff have little opportunity for such growth (Spetz et al., 2019).

Experts suggest that federal policies could support career ladders, including sustained funding provided by Congress to local industry partnerships to develop career pathways and regional, industry-specific training, hiring and advancement strategies. Congress could also provide targeted support to these industry partnerships to help employers, unions, training providers and other stakeholders adopt and measure equitable and inclusive practices around hiring, compensation, retention, and advancement (National Skills Coalition & Business Leaders United, n.d.; LeadingAge, 2021b). Recent recommendations stemming from the RAISE Family Caregiving Act (Administration for Community Living, 2020) recommend the U.S. Department of Labor conduct research, convene think tanks, and provide technical assistance on career ladders to help retain DCWs (RAISE Act Family Caregiving Advisory Council & Advisory Council to Support Grandparents Raising Grandchildren, 2022).

States can support adding career ladders and promoting career growth and advancement in several ways. States can mandate high-quality, buildable trainings tied to wage increases, credentialing systems, and education stipends. Reinforcement of these will help new home care workers become attached to the field (Milbank Memorial Fund, n.d.). A few states have incorporated career ladders into policy. In 2021, the Wisconsin Governor's Task Force on Caregiving included recommendations to develop "career ladders for caregivers leading to potential certification as a nurse aide" (Winters et al., 2021). Likewise, Colorado's Clear Career Progression identifies a career ladder from entry-level (e.g., home health aide, personal care aide) to

mid-level (e.g., registered nurse [RN]) and advanced (e.g., nurse practitioner) occupations (National Skills Coalition & Business Leaders United, n.d.).

Industry partnerships are a proven multi-stakeholder approach to helping workers enter and advance along career pathways and helping local companies and subsectors within an industry support an inclusive talent ecosystem (National Governors Association, 2021). State partnerships with PHI are one such example. PHI has partnered with multiple states to develop career ladders and training for DCWs.

Integrating DCWs into interdisciplinary care teams is one form of career ladder promoted by PHI and others (PHI, n.d.-d; Stone & Bryant, 2019). Elevating DCWs to roles that are integrated into care teams provides career advancement opportunities, increased compensation, and possible improved job satisfaction. Utilizing DCWs in this way may also improve care quality and outcomes (PHI, n.d.-d). Allowing more nurse delegation, as described in ***Section 3.1.9***, is one way to better integrate DCWs into interdisciplinary care teams (Stone & Bryant, 2019).

Other examples of advanced roles for DCWs include: condition-specific specialist roles, such as diabetes or dementia specialists; senior aides, who provide a range of support for home care workers, family caregivers, and consumers; and health coaches, who can support consumers to achieve individualized health and wellness goals (PHI, 2019).

3.1.9. Expand Worker Roles and Responsibilities Through Nurse Delegation

Nurse delegation allows a nurse to train and supervise aides to provide routine skilled tasks such as medication administration, rather than relying solely on a nurse to complete that medical task. This is not only beneficial to the home care recipient but can provide a career ladder for aides insofar as their increased scope of work and level of responsibility is rewarded with higher pay. Delegation can offer opportunities for professional growth, increase retention of these workers, and save money when a more affordable workforce can complete the needed tasks (Spetz et al., 2019). Nurse delegation also expands access to HCBS by increasing the availability of staff who can meet client needs (Anthony et al., 2017).

As workforce shortages continue and competition for RNs grows, the recommended strategy to have more nurses delegate and supervise approved tasks to trained home care workers will potentially alleviate some pressure on an overburdened care system and at the same time provide growth and development opportunities (State Senate, 2013). However, research on the impact of delegation to home care workers is needed to understand both consumer and worker outcomes (Spetz et al., 2019).

For efforts to make advanced training and nurse delegation of routine "skilled" tasks to aides successful, it may be necessary to overcome stiff resistance from licensed nurses. Osterman (2017) recounts the legislative struggle in New York to get advanced aide training and nurse delegation to permit agency-employed home care aides to perform even simple tasks, such as administration of pre-packaged, pre-measured medications to home care clients. First introduced in 2013, this proposed legislation repeatedly failed due to strong opposition from nurses. The New York State Nurses Association argued that there would be adverse health consequences if home care agency-employed aides rather than nurses were permitted to administer medications (although the Nurse Practice Act already contained exemptions for consumer-directed aides providing home care to Medicaid and private pay clients to do so, with or without receiving training and supervision from a licensed nurse). Even after the Nurses Association dropped its objection, the SBON, the government agency that licenses nurses and defines their scope of practice under the Nurse Practice Act, continued to oppose nurse delegation to agency-employed aides.

The legislative logjam was finally overcome when CMS refused to approve New York's state plan amendment to add the Community First Choice (CFC) benefit to Medicaid unless New York equalized access to performance of paramedical tasks by both agency-employed and consumer-directed home care aides and for all populations of home care recipients (that is, including older people, younger adults with physical disabilities, and children and adults with intellectual developmental disabilities). Gaining approval to offer the CFC state plan benefit to PCS was desirable because New York could claim six additional percentage points of federal financial participation for Medicaid recipients whose severity of disability-related need for PCS met coverage criteria for nursing home care (Federal Register, 2012). Disability advocates lobbied strongly on behalf of the legislation, which, to overcome nurses' resistance, incorporated extensive and expensive nurse supervision requirements (Osterman, 2017).

It is also important to understand that trained medication aides routinely dispense prescription medications in nursing homes and assisted living facilities in most states (Wanga, 2022). Consumer-directed home care aides also routinely dispense medications in many states either under nurse delegation provisions or because they are exempt from Nurse Practice Act provisions requiring nurse delegation of medication management that apply to agency-employed home care aides (Reinhard, 2001).

3.1.10. Create Worker Registries to Retain Existing Workers and Attract New Workers

Registries of DCWs are another recommended strategy to retain and attract new workers to the field (Espinoza & Diskin, 2020; CMS, 2016). Worker registries provide information to consumers about available workers and, often, their training or credentials. This allows consumers to identify workers and allows workers to advertise their services directly to consumers. Other benefits include: (1) preventing unnecessary re-training of staff if their training credentials are documented in these registries; and (2) helping providers and consumers find replacements if turnover occurs (MPR, 2005). Some states have established registries targeted specifically at Medicaid HCBS users; however, other registries such as Care.com emerged primarily to serve private pay clients. It is unclear how many or which registries serve both Medicaid self-directing HCBS recipients and private pay home care clients.

3.1.11. Increase the Pipeline of Available Workers

Literature and advocates have recommended expanding the pipeline of eligible applicants to DCW positions (Barnett, 2022; Winters et al., 2021; Long-Term Care Commission, 2013) and suggested removing barriers to entry into the direct care workforce (National Governors Association, 2021). Industry partnerships are regarded as key to creating a national pipeline of workers (Scales, 2022), and the role states can play in these partnerships is key to addressing pipeline challenges (Scales, 2022). For example, some states allow training for direct care jobs to count toward high school or college credit. Arizona, Tennessee, and Washington state have created these types of programs in recent years and other states are working on or considering implementing these types of programs. In addition, 32 states plan to use ARP Act funds to develop programs to improve DCW recruitment (MACPAC, 2022).

International recruitment, including immigration reform, has also been recommended as an important strategy for attracting additional workers (LeadingAge, 2021c; National Governors Association, 2021; National Consumer Voice for Quality Long-Term Care, 2013; PHI, 2023b).

3.1.12. Collect Data on the Workforce to Measure Outcomes

Some suggest that states could be funded to better measure outcomes of their efforts to recruit and retain DCWs (National Skills Coalition & Business Leaders United, n.d.). National workforce data are incomplete. Data gaps have been noted as a barrier to adopting VBP methods (PHI, 2019), which were discussed in ***Section 3.1.3***. Many states are not gathering important data on DCWs. Even when data are collected, differences in data

collection methods and job nomenclature have hampered comparisons across direct care occupational categories and settings. Available data are often insufficient to understand and address gaps, to inform policies to support DCWs, and/or to measure the impacts of policies over time (Edelstein & Seavey, 2009). Additionally, data on workers should be measurable by race/ethnicity and gender to continue to address workforce disparities (PHI, 2022b). One example of a state collecting outcomes is North Carolina. Its HCBS state plan includes a workforce survey to collect data on workforce challenges and to disseminate statewide, systems-level recommendations (Scales, 2022).

3.1.13. Implement Cross-Cutting Programs

Some states have implemented cross-cutting programs aimed at increasing worker recruitment and retention and also improving quality. For example, the North Carolina New Organizational Vision Award (NC NOVA) program was developed nearly 20 years ago but is receiving renewed attention (Taggart & Fox-Grage, 2022). NC NOVA is a special licensure category developed by the state of North Carolina as part of the Better Jobs Better Care project. Home care, and other providers, can receive this license by implementing a set of defined workplace interventions to improve the recruitment and retention, quality, and job satisfaction of direct care staff. This includes elements of improved training and career ladders described above. An evaluation of this program found that average annual turnover among NC NOVA home care agencies was 12% lower than average statewide home care agency turnover (Harmuth & Conrad, 2010).

3.2. Actions New Jersey Has Taken to Improve Direct Care Workforce Recruitment and Retention

New Jersey has implemented many -- indeed almost all -- of the above-recommended strategies to improve recruitment and retention of home care workers. These efforts have occurred within the context of other policy changes New Jersey has taken to re-balance the LTSS system away from institutions to more HCBS. New Jersey has been re-balancing their spending away from institutionalized care and towards HCBS for many years (Murray et al., 2021; Christ & Sherman-Greenup, 2022). Expanding access to HCBS requires both maintaining existing staff and increasing the supply of home care workers to meet the growing demand for home-based care. Stakeholders we spoke to about New Jersey's experience with efforts to improve worker recruitment/retention described achieving some successes, especially with respect to improving wage rates, but also highlighted ongoing challenges. Some stakeholders made very specific recommendations for improving existing approaches -- such as streamlining the training and credentialing process -- to reduce the unintended adverse consequences these requirements may have on recruitment and retention of home care workers.

3.2.1. New Jersey Initiatives toward HCBS

As detailed in the ***Background*** section, the state has a long history of expanding HCBS, both traditional and self-directed care. Take up of the self-directed services option has increased greatly relative to use of traditional agency-delivered aide services in recent years (DMAHS, 2021).

People who are eligible for HCBS through the New Jersey DHS Division of Developmental Disabilities (DDD) are also able to participate in self-direction under the 1915(c) Supports Waiver, which is not part of the "1115" Family Care Plan. Some HCBS recipients with IDD may receive self-directed services via both the PPP and the Supports Waiver. The Supports Waiver operates on a fee-for-service basis and is administered by the New Jersey DDD. All Supports Waiver enrollees receive individual budgets based on an individualized assessment using a standardized tool and scoring system that assigns them to one of five "tiers" (A-E), each of which has a maximum spending limit, with Tier 5 offering the highest budget limit. These budgets may be used for traditional, professional managed/delivered services, for self-directed services, or some of each (NJ DHS/DDD, 2023). The Supports Waiver individual budgets are typically much more generous than PPP budgets and self-

directing Supports Waiver participants can afford to purchase more aide hours and pay higher hourly aide wages (up to $25 per hour).

The number of people who use self-direction in New Jersey continues to grow. Stakeholders reported that the number of people who chose self-direction significantly increased during the COVID-19 pandemic and subsequent PHE. One MCO reported, “Prior to the pandemic we must have had about 2,000 members [utilizing self-direction]. Now we're at maybe 3,500 or close to 4,000 members with that service.” State officials agreed that the pandemic led to increased enrollment in self-direction, noting that about 9,000 people were enrolled in 2018 and over 26,000 utilize self-direction now.

Some of the increase in numbers of self-directing HCBS users can be attributed to a decrease in availability of agency-based staff during the PHE. However, stakeholders also noted that preferences seemed to change for both DCWs and consumers during this time. Some workers made the decision to leave the field during the PHE because they were uncomfortable going into people’s homes or for other personal reasons (e.g., school, and childcare closures). At the same time, consumers were more hesitant to allow people into their homes. This shift in preferences has persisted as people found they enjoyed the freedom and control they had over who they staffed and how much they paid.

> *We had previously a lot of family members but not parents, spouse, and guardian. The pandemic, we got Appendix K flexibility to allow that, and we did change that to a permanent policy change, because that's helpful for our individuals and their continuity.*
>
> *—State official referring to the IDD Supports Waiver*

Although the PPP and other self-directed programs may lessen the demand for agency-based workers, early research showed that recruitment of PCAs was difficult for people who could not identify family members or friends to hire (Foster, Phillips, & Schore, 2005). Stakeholders agreed that most people who enroll in self-direction have an identified caregiver. Those who turned to other sources outside of family or friends often found it difficult to fill the positions. The parent of one service recipient reported that even if a worker gives 60-days’ notice, they still have a hard time finding a replacement worker in time.

The availability of self-directed services for persons with IDD under the 1915(c) Community Care Waiver and, especially, via the Supports Waiver is also credited with increased take up of the self-directed services option. The Supports Waiver began to operate under fee-for-services auspices (outside of the MLTSS Family Care “1115” waiver) under the administration of the state DDD in 2017. The Community Care Waiver primarily funds services for group home residents whereas services for HCBS users with IDD living in private homes, usually with family, are funded mainly via the Developmental Disabilities Supports Waiver. Participants in the Supports Waiver receive individual budgets, which they can use to purchase professionally managed and/or self-directed aide services as well as a range of other goods and services, some of which may be from traditional providers, others of which are self-directed and non-traditional. Supports Waiver budgets are calculated based on an individualized assessment of need for HCBS using a standardized tool that assigns applicants to one of five benefit “tiers” (A-E) with tier E being the highest level (NJ DHS/DDD, 2020). These budgets can be quite generous (NJ DHS/DDD, 2022), ranging from a low of nearly $26,000 to almost $104,000 in the Supports Waiver and up to four times greater in the highest tier in the Community Care Waiver. However, only a portion of the budget (designated for individual and family supports) can be used to purchase aide services (agency-delivered or self-directed), ranging from about $6,000 to $19,000 in the Supports Waiver but over $300,000 in the Community Care Waiver.

According to the New Jersey DHS/DDD, the current average wage paid to self-directed employees (SDEs) is $18.83 but the agency permits self-directing Supports Waiver participants to pay aides up to $25 per hour. Also, under special circumstances, they may request permission to pay an “enhanced reasonable and

customary wage" which, in the case of individuals who require skilled nursing care and employ a RN could be as high as $48 per hour (NJ DHS/DDD, 2023b).

During the PHE, New Jersey used Appendix K to allow parents, guardians, and spouses of self-directing individuals enrolled in IDD waivers to become paid caregivers to alleviate worker shortages (CMS, 2020). This change has been made permanent, according to state officials. Of note, these caregivers cannot act as both an authorized representative and a worker, meaning people who are providing care cannot also oversee paying themselves for that care.

Take up of self-directed services via the PPP also increased after enrollment in MLTSS plans became mandatory because MCO contracts with the state require MCOs to inform plan members eligible for PCS that they can choose to receive traditional agency-delivered aide services or self-direct their services via the PPP. MCO representatives and state officials noted that MCOs do not get involved with finding workers for PPP participants, but they have been helpful in raising awareness about the availability of self-direction as an option and ensuring consumers understand the program. MCO representatives indicated that whereas they describe self-direction as an option, they do not promote or recommend it unless plan members in need of home care services are unable to find agencies with sufficient workers to serve them or are dissatisfied with agency services, which plan members living in rural areas more often experience. MCO representatives also said that for plan members with high needs, MCOs will pay agencies more than the state-mandated hourly reimbursement rate to ensure that such individuals obtain necessary care but doing so can be extremely difficult even when providers are offered enhanced reimbursement.

MCO representatives also said that they understood why plan members might wish to enroll in the PPP so they could have the flexibility to choose family members, friends, and neighbors they know and trust as paid aides. However, they also expressed reservations about self-direction. While home health/home care agency association representatives felt MCOs were pushing people towards self-direction, MCOs stated that self-direction is more work for their case managers, which costs them more money. Interviewees affiliated with the Financial Management Services (FMS) entity for PPP said that this is something they continually need to educate MCOs about. The FMS entities provide support services to self-directing program participants, including both financial oversight (to prevent fraud and abuse) as well as counseling that serves as the "first line of defense" which should lessen the burden of anti-fraud and quality of care oversight on MCO case managers. MCOs pay less for home care when plan members choose PPP because self-directed budget allocations are calculated based on an hourly aide rate that is lower than what MCOs would have to pay agencies that serve clients assessed as having the same level of service need. This differential is based on the inclusion of agency overhead expenses in the Medicaid hourly reimbursement rate to agencies. Whereas agency overhead accounts for at least 20% of agency hourly rates, Medicaid reimbursement for FMS and counseling services is limited to 12.5%, on average, of PPP budgets (Horvath, 2023).

Some MCO interviewees also expressed the opinion that self-direction opens consumers up to more risk for fraud and abuse and poor-quality care because, unlike agency-employed aides, PPP aides do not have CHHA training and nurse supervision. It is not clear what evidence informed MCO representatives' concerns about the heightened risks associated with self-direction.

> *Especially in the areas where we already know it's a hard to service area… [case managers can] say, "Hey, we also have this other option of participant-directed services." And so once they explain what it is, people are definitely much more open to receiving it. Even when they have to wait 60 to 90 days of getting on the program… A lot of our unstaffed cases, the ones that have been waiting and attempting to find an agency, they typically will go the PPP route.*
>
> *—MCO representative*

Although the CCDE documented better outcomes for self-directing program participants in New Jersey and the other two participating states compared to users of traditional agency services, these findings

were published nearly 20 years ago, which may explain why MCO interviewees appeared unfamiliar with them. Very little evaluation research comparing outcomes for self-directed versus agency-delivered aide services has been conducted in New Jersey or elsewhere since, with the notable exception of research on the Veterans Health Administration's Veterans-Directed Services program. Although this research is still ongoing, published findings thus far have found either more positive or no different outcomes for self-directed aide services compared to agency-delivered aide services (AARP & Commonwealth Fund, 2017).

PPP participants receive only limited help from "counselors" with respect to hiring aides. However, in the 2024 contracts between the state and the MLTSS plans, MCOs will assume responsibility for contracting with FMS/counseling providers rather than accepting the state's choice. At least one MCO, according to an interviewee, may decide to take on this function rather than contract it out. Also, MCOs may offer registries to help plan members who choose to self-direct find workers if they cannot or prefer not to hire family, friends, or neighbors. In the IDD fee-for-service program, consumers may hire a supports broker to help with recruiting staff, but using that service is an additional cost that comes out of the individual's budget.

3.2.2. New Jersey Steps to Increase Direct Care Compensation

DCW compensation is widely regarded as the key to improving home care worker recruitment and retention rates. Hourly wage rates and overall annual earnings for home care workers need to be competitive with other, primarily service sector, jobs that require similar or lower pre-employment skills training and educational attainment. A recent report on the differential hourly wage gap between home care worker wages and hourly wages for other entry-level jobs found that home care workers in New Jersey were paid approximately $3.73 less (Khavjou et al., 2023). In contrast, a U.S. Department of Labor, Bureau of Labor Statistics report (2023) suggests that New Jersey has been more successful than most other states in keeping home care worker compensation (as measured by hourly wage rates) competitive with other jobs to which individuals considering becoming agency-employed CHHAs might also be attracted. However, our case study interviewees shared less optimistic views about how competitive home care aide jobs in New Jersey are with other jobs available to individuals in the target labor pool. Several interviewees pointed out, for example, that Walmart cashier and Amazon warehouse jobs paid higher hourly wages compared to New Jersey's state minimum wage and starter salaries for agency-employed CHHAs and were also more attractive in other respects (e.g., no pre-employment training requirements, less on-the-job physical strain, etc.).

New Jersey is one of 23 states that has committed to raising the state minimum wage for all hourly wage earners to $15 per hour. New Jersey will reach this goal in 2024, after which the minimum wage will be annually indexed to inflation. Currently (2023), New Jersey's minimum wage is slightly above $14 per hour. This commitment to guaranteeing a "living wage" for all wage workers required New Jersey to increase Medicaid home care payments to enable home care workers to receive at least the state's minimum hourly wage and preferably more. However, it has been difficult for the state to raise Medicaid rates sufficiently to maintain a sizable differential between home care worker wages and the state minimum wage. One interviewee noted that when the New Jersey minimum wage was $10 per hour, the average hourly wage for CHHA's was about $15 per hour and that a similarly sizable pay differential no longer exists. Other interviewees observed that employers competing for workers from the same labor pool may offer more than the state minimum wage in response to supply and demand factors, whereas Medicaid reimbursement rates are legislated and are less directly responsive to such market forces.

Beginning in 2003, New Jersey has used WPTs to increase wages for nursing home-based staff funded through a trust that is partially comprised of assessments paid by nursing homes (Yearby et al., 2020). In June 2021, the New Jersey Legislature passed a WPT policy which appropriated funds for the specific use of increasing wages for PCAs (State of New Jersey, 2021), but not other types of home care workers.

In response to the increased minimum wage, the state recognized that wages for DCWs also needed to increase. A wage floor was set for nursing home-based DCWs (NJ Administrative Code, 2020), but no similar action was taken for home care workers. However, a review of approved budgets from the previous five fiscal years (FYs) has shown other attempts at keeping the wages of various types of home care workers competitive. A summary of compensation-related budgetary language is highlighted in the ***Exhibit 2*** below. In some years, these rate increases have been tied directly to worker wages, but in others they have not.

Exhibit 2. HCBS DCW Rate Increases in New Jersey Budgets

	FY 2019[a]	FY 2020[b]	FY 2021[c]	FY 2022[d]	FY 2023[e]
DSP	$20,000,000 in budget towards wage increases	$40,000,000 in budget towards wage increases	$43,992,000 in budget towards wage increases plus funding for additional $3/hr from October-December 2020	$43,992,000 in budget towards wage increases	$43,992,000 in budget towards wage increases
PCS Delivered by Agency-Employed CHHAs	$19/hr or $16/hr if employed through MCO	$19/hr	$20/hr	$22/hr (through WPT and FMAP) plus funding for additional $1/hr through March 2024	$24.52/hr
Private Duty Nursing	$10/hr above the FY 2008 rate	$10/hr above the FY 2008 rate	$60/hr for RNs and $48/hr for LPNs	$60/hr for RNs and $48/hr for LPNs	$61/hr for RNs and $49/hr for LPNs

NOTES:

a. State of New Jersey Appropriations Handbook, Fiscal Year 2018-2019. Retrieved from: https://www.nj.gov/treasury/omb/publications/19approp/FullApropAct.pdf.
b. State of New Jersey Chapter 150 Appropriations Act, Anticipated Resources for the Fiscal Year 2019-2020 Retrieved from: https://pub.njleg.gov/Bills/2018/AL19/150_.PDF.
c. State of New Jersey Chapter 97 Appropriations Act, Anticipated Resources for the Fiscal Year 2020-2021. Retrieved from: https://pub.njleg.gov/Bills/2020/AL20/97_.PDF.
d. State of New Jersey Appropriations Act, Anticipated Resources for the Fiscal Year 2021-2022. Retrieved from: https://pub.njleg.gov/bills/2020/A9999/5870_I1.HTM.
e. State of New Jersey Chapter 49 Appropriations Act, Anticipated Resources for the Fiscal Year 2022-2023. Retrieved from: https://pub.njleg.state.nj.us/bills/2022/AL22/49_.PDF.

Despite these increases, there are still challenges with compensating DCWs at a rate that improves recruitment and retention. One home health/home care agency association representative reported that because Medicaid rates are lower than private market rates, it is more challenging for agencies to cover costs in their price structure compared to other industries. An MCO reported that "although the rate[s] went up (referring to hourly Medicaid rates for agency delivered aide services), it's not necessarily something that the aides directly received the benefit of." Another representative from an MCO reported that when the state sets rates, it undermines their "ability to contract for minimum rate" and "to use contract leverage to drive outcomes."

Some MCOs are using higher rates to attract workers and staff difficult cases. Representatives from two MCOs and an association reported that they use enhanced rates as an incentive to staff difficult cases or hard to service areas. These higher than state-mandated reimbursement rates appear to apply to agencies only, not to the enhancement of PPP budgets.

The current agency reimbursement rate includes a mandatory $1 pass-through. However, several interviewees questioned whether the state is monitoring agencies to ensure and enforce compliance. One MCO representative noted that agencies are required to submit reports that can be accessed by request. Assuming that agencies are honoring the pass-through requirement, it appears that the current Medicaid rate is sufficient to allow agencies to pay their workers $17-$18 per hour as well as pay related labor costs (e.g., employer's share of mandatory payroll taxes, worker's compensation coverage, mandatory paid leave, plus costs of employer-sponsored health insurance if required) and provide for 20% of the Medicaid reimbursement rate to cover agency overhead costs. CMS recently published (Federal Register, 2023) a Notice of Proposed Rulemaking (NPRM) with a provision which, if it is included in the final rule, will require states to limit to 20% the allowable cost of the "overhead" component of hourly Medicaid home care reimbursement rates to home care agencies.

Agency "overhead" expenses include all costs not directly associated with direct care labor. These include office rent and equipment costs, salaries/wages paid to non-direct care staff including receptionists, bookkeepers, agency managers, nurses and social workers who supervise aides and conduct needs assessments, staff recruitment costs (e.g., newspaper ads, online job posting fees), and training costs (if paid by the agency). One interviewee noted that home care agencies had experienced additional overhead expenses associated with the federal legislative mandate requiring implementation of electronic visit verification (EVV) for home health and personal care aide services. This same interviewee also said retention rates of home care aides were adversely affected by the EVV mandate, which many aides resented -- which meant higher recruitment costs for agencies resulting from higher aide turnover.

> *We've been very successful in staffing the cases in the hard to service areas, but that comes at a price, of course. We do single case agreements, and we negotiate special rates for those cases. And that's how we've been able to get around some of the difficulties with staffing cases in the hard to service areas.*
>
> *—MCO representative*

Job postings on behalf of New Jersey agencies seeking CHHAs on sites such as Indeed.com and ZipRecruiter indicate that agencies are advertising jobs that pay between $15 per hour (starter rate) and $25 per hour, with hourly wages on offer clustering between $17 and $19. Wages at the higher end of the range are typically being offered by agencies seeking hospice aides (likely covered under Medicare home health/hospice rates) and by assisted living facilities which cater predominantly to private payers.

Budgets for self-directed participants also had to increase to keep pace with New Jersey's minimum wage increases because the state found consumers were sacrificing service hours to cover wages. New Jersey raised the basis for calculating PPP budgets derived from the standardized PCS needs assessment from $15 per authorized hour to $19 per hour after state policymakers realized that because of annual increases in the state's minimum wage, PPP budgets would soon become insufficient for PPP participants to pay their aides the minimum wage unless they cut back on the number of hours they purchased. The differential between the agency hourly rate and the PPP hourly rate used to calculate the amount allocated to each participant's individual budget recognizes that agencies have administrative overhead expenses. PPP program participants receive support services in the form of FMS and individual counseling to help them manage their budgets, including paying and filing the employer's share of payroll taxes and purchasing worker's compensation coverage. PPP participants do not pay for these support services from their budgets. Instead, the state contracts separately with two different organizations that offer both financial management and counseling services: Public Partnerships Limited and Easter Seals. Self-directing program participants in the PPP and Supports Waiver can choose between them. On average, the cost of these support services amounts to about 12.5% of the total PPP per participant cost, which is less than the share of Medicaid agency reimbursement that goes toward overhead expenses (David Horvath, personal communication, 2023).

Labor costs for self-directed aides that self-directing program participants must pay from their budgets include not only hourly wages but also the employer's share of payroll taxes for Social Security, Medicare, and unemployment insurance. When these extra labor costs are factored in, PPP program participants have sufficient funds to pay their aides a little over $17 per hour to purchase all the aide hours they were assessed to need. If they need to pay more, which can be necessary to recruit workers who are not family, friends, or neighbors (for whom personal bonds may motivate acceptance of lower pay) they can only do so by reducing the amount of aide hours they purchase. In contrast, self-directed participants and their representatives enrolled in IDD waivers are routinely permitted to pay their aides up to $25 per hour and sometimes more with special permission based on medical need and skilled care credentials of home care workers. While $25 per hour is more than DSPs obtained via agencies typically make, one IDD service recipient's representative noted that it is still difficult for her to find the help required by the "high need" consumer she represents with this hourly wage cap in place. In her words, because of the high-acuity care needs of the person she cares for, "There isn't a [self-directed employee] on the planet I could get for $25 an hour who could do this job." To find DSPs, she has had to find legal ways to pay people per diems and bonuses for their work. A financial management service provider, however, reported that the $25 per hour rate is considered "reasonable and customary" and that it was an improvement from a previous cap of $15 per hour. This respondent noted that challenges arise when a person starts workers at $25 per hour and then is unable to provide wage increases to retain workers.

CMS approved New Jersey's HCBS spending plan for using temporary FMAP matching funds available through the ARP Act in October 2021 and outlines various ways New Jersey intends to use this funding to improve wages for home care workers (State of New Jersey, 2021; New Jersey DHS, 2021). These changes included increased wages for PCAs, increased hourly rates for calculating the PPP budgets, and more money towards the rates of home care workers in the New Jersey Assistance for Community Caregiving Program. Additionally, the plan allocated funds for recruitment and retention bonuses at the beginning of employment and after one year with an agency. It is too early to assess how impactful these changes will be on improving recruitment and retention of DCWs.

Finally, New Jersey's ability to determine Medicaid payment rates for PCS appears to be the most powerful lever the state has to improve home care worker compensation. However, Medicaid is not the only payer source for home care. Whereas Medicaid is the predominant payer for HCBS for service recipients with developmental disabilities and for "working age" (18-64) adults with adult-onset, primarily physical, disabilities, this is not so for older adults (aged 65+). Medicare covers some home health aide/hospice services for elderly/disabled Medicare beneficiaries who are eligible for Medicare covered home health agency or end of life hospice services at home. There is also a rapidly growing private pay market for home care. Nationally representative surveys of older Americans indicate that nearly two-thirds of older Americans who receive any paid home care pay for all or some of it privately, mainly out-of-pocket albeit sometimes with private long-term care insurance coverage (Janus & Ermisch, 2015). According to the most recent Genworth Cost of Long-Term Care Survey (2021), private payers in New Jersey should expect to pay $29.95 per hour for home health aide services and $29 per hour for homemaker aide services. Whereas some home care agencies serve primarily or exclusively Medicaid HCBS recipients, others known as "private duty" agencies cater primarily or exclusively to private pay clients and some serve a variable mix of public/private pay clients. Because private payers pay higher rates for home health/home care aide services ($29.95 per hour in 2021 according to the Genworth Cost of Care Survey), agencies may be financially motivated to seek private pay clients. Private payers may both subsidize the cost of aide services for Medicaid recipients and reduce their access to aide services insofar as agencies faced with worker shortage prioritize services to clients eligible for Medicare home health/hospice services or who can pay privately for non-Medicare covered aide services.

3.2.3. New Jersey Training Requirements

Each of the state agencies responsible for regulating various DCW roles in New Jersey also manages the training requirements for that profession. DSPs and SDEs are DCWs that support people living with disabilities in the community who receive aide services under IDD HCBS waiver programs. DSPs are regulated by the New Jersey DHS/DDD and supported by the New Jersey Partnership for Direct Support Professional Workforce Development (NJ DHS/DDD, n.d.). The College of Direct Support provides DSPs with required training and continuing education and helps increase retention by creating a professional career path (NJ Partnership for Direct Support Professional Workforce Development, 2010). DSP and SDE training provided by the College of Direct Support is provided mainly online.

CHHAs are regulated by the New Jersey Board of Nursing, and the agencies that employ them are regulated by the New Jersey Division of Consumer Affairs (NJ Division of Consumer Affairs, n.d.). CHHAs are required to undergo a 76-hour training program, evaluation, and background check (NJ Division of Consumer Affairs, 2019). The training requirement includes 60 hours of classroom-based learning and 16 hours of clinical instruction supervised by a nurse. Once completed and certified, CHHAs must be recertified every 2 years; no retest is required but there is a recertification fee of $30. Agencies must provide 12 hours of in-service continuing education annually (Care Academy, 2020).

PCAs can either be employed by agencies or employed by individuals through the PPP. Individuals employed through agencies are regulated under the New Jersey Department of Health. They are required to undergo a nurse aide training course and pass the New Jersey Nurse Aide Certification Examination (New Jersey Administrative Code, 2022). PCAs employed by participants in the PPP are not regulated by the state (PHI, n.d.). It has long been a tenet of the “self-direction philosophy” that self-directing program participants or their representatives should train their workers themselves or should decide what training their workers require and arrange for it to be provided. Funds from the PPP budget can be used to cover training costs; however, training may be available at no or low cost from organizations such as the Alzheimer’s Association. In 2021, a bill was passed which requires DMAHS to develop a program to train family members of people enrolled in NJ FamilyCare as certified nursing assistants (CNAs), if they choose, at no cost to the family (State of New Jersey Senate, 2020; Ward et al., 2021). These family members would then be employed by a private duty nursing agency to provide CNA services to the NJ FamilyCare participant under the supervision of a RN. New Jersey also dedicated money from the ARP Act to implement a voluntary training program for independent providers employed by self-directing PPP participants (State of New Jersey, 2021).

> *We find that the big barrier is, once they're done with the certification, then everything after that is a big delay. And when someone who is not making a large wage and we say, "Okay, you just did this certification maybe for a week at eight hours a day and now you have to wait till we get all of your fingerprinting done. You have to wait for the board of nursing or DCA to get all of the information and approve you. And in that time period, you can't work." That's where the providers say they'd lose a lot of people.*
>
> *—State official*

Stakeholders reported that administrative delays in receiving required training, testing and certification along with delays in getting criminal background check results and the associated costs that applicants may be required to pay create barriers and disincentives for individuals applying to work for home health/home care agencies. The lack of options for training/testing in the worker’s primary language is another obstacle.

Multiple stakeholders reported that the most common barrier related to home care worker training is the extensive delay workers experience while waiting for their certification testing, background checks and credentials from the Division of Consumer Affairs and SBON. A “timeline” for the three phases each of the “initial” and “endorsement” portions of the application/approval process posted on the Consumer Affairs website

(https://www.njconsumeraffairs.gov/hhh/Pages/Phases-and-Timelines.aspx) shows the complexity involved. One interviewee recalled the process taking 6-7 weeks. However, the wait can be much longer. Interviewees pointed to a backlog at the last stage when the SBON reviews the application, proof of training and successful test results, criminal background check findings, and proof of an offer of employment from a home care agency, approves the application and then delivers the CHHA certificate, without which workers cannot be hired and paid by agency employers. Agencies often lose workers who find other employment during this waiting period. Also, individuals who have completed the training and testing must obtain a promise of employment from an agency to receive their certification from the SBON. They then must start working for the agency and maintain employment with this or another agency. If they stop working for an agency and their certification comes up for renewal (which it does every 2 years) they will likely lose their certification. They want to start working for an agency again, they may be required to re-take the training, pass the written and practice skills demonstration test again, and re-apply for their CHHA credential.

Other barriers mentioned by stakeholders include the mode of training. An academic researcher shared that some discussion in the field has focused on how the 76 hours of training is obtained (e.g., in a classroom, simulation, or patient's home), rather than how many hours are required. An association representative shared that more hands-on hours would be "a whole lot better." A representative from another association reported another difficulty of home care aide training is that it is in-person rather than virtual. Much of the training except for the 16 hours of hands-on practice, could be provided on-line and some virtual training took place during the pandemic. Although there has been no action, an academic researcher reported that there has been talk of a need for initiatives to attract more faculty to train home health aides, suggesting a potential shortage in individuals available to train home care workers.

Despite the high percentage of immigrant home care workers whose native language is not English and including 19% of CHHAs surveyed by the NJCCN (2022) who reported their English proficiency as "poor," CHHA training or testing is rarely provided in Spanish or other non-English languages.

Although there was general support in having a required training, some stakeholders questioned the quality of the current training. An academic researcher reported that home health agencies have mixed perceptions of 76-hour training; some agreed with and supported the requirement, while others reported that it delayed their staff's readiness to work. One MCO representative reported that required trainings improved member safety and quality of care; however, another MCO representative shared that based on member complaints regarding staff training, they did not think the training was consistently delivered by all agencies. Although they did not comment on the quality of training, one state official shared that worker trainings are conducted by the providers themselves, rather than through standalone schools, introducing the possibility for variation in how training is delivered across the state. A different state official observed a decrease in the robustness of trainings offered by agencies, presumably to cut costs. MCO representatives and state officials reported that training was not always provided in workers' primary language, hindering understanding. An MCO representative and service recipient also suggested that workers should receive more training on de-escalation techniques and other specific skills to better help members with behavioral health issues.

> *There needs to be a training program provided by the state to properly train people to be DSPs. This isn't a job that just anybody off the street can do. They really need to have training. Whether it is… personal hygiene, how to take care of an individual's hygiene, how to prepare meals, medication, everything that a parent would need to know what to do to take care of their child a DSP basically needs to know what to do.*
> *—Parent of service recipient*

Stakeholders reported mixed perspectives on expanding training specifically for SDEs. An academic researcher shared that offering training for workers in the PPP may encourage some workers to remain in the labor market after their service with a family member or friend is no longer needed. FMS representatives agreed, explaining that workers caring for family members then would be better qualified

to be hired by others, including agency employers. They supported training and career advancement, sharing that it could "only mean good things for this population." However, one FMS provider reported facing resistance when they increased required SDE trainings in 2017 to align with trainings required for DSPs. Families saw the requirement as too much of a burden and did not see the need for it if family members or other directly employed aides had already been working for the family or individual for years. An MCO representative similarly shared that if training for self-directed workers was mandated, they believed it would decrease worker recruitment because many times, the caregiver has an additional full-time job outside the home. One parent of a service recipient explained that there was an absence of initial trainings to help members and home care workers feel more comfortable taking on the job and that new training only seemed to be enforced after a horrible incident. To meet the specific needs of her child, another parent shared that she developed her own SDE training and requires any new SDE to shadow the family for a minimum of 3 months.

Some stakeholders described current efforts to improve or offer new training. An association representative reported that Consumer Affairs felt training should be "beefed up" and that they are working to revamp the curriculum. Core changes would include one credential for both CNAs and home health aides rather than two separate credentials obtained from two different departments (i.e., Consumer Affairs & Department of Health). The administrative burden and required bridge of 10 additional training hours needed to work in both settings prevented workers from practicing both roles.

State officials also mentioned a pilot program for home care worker retention that will offer specialized training to already certified home health aides. Additional training will include topics such as behavioral health, dementia, mental health, and first aid with the goal of empowering workers to handle service recipients with additional needs safely and confidently. One MCO shared that they are trying to offer training and education for caregivers in the PPP to improve the quality of care received by members and to address caregiver burnout. A state official reported that the state formed a DSP competency and capacity building steering committee whose goal is to review existing trainings for DSPs and SDEs and make recommendations to update, remove, and add trainings. The expected completion of their work was Spring 2023.

3.2.4. Reducing Costs to Workers for Training in New Jersey

A free online guide lists New Jersey CHHA training sites, including agencies that cover training costs. (Home Care Training Guide, 2023). Multiple stakeholders offered perspectives on how the cost of home care worker training was covered. Representatives of different stakeholder groups differed in what they said about who pays for mandatory CHHA training. State officials were more likely to say that agencies covered training costs and that the state expects them to do so. In contrast, interviewees representing the home health/home care industry were more likely to say that sometimes agencies covered training costs, especially given severe staffing shortages during the pandemic. However, other industry representatives said that agencies often require trainees to pay for training upfront, in the belief that this will prevent them leaving after the training is paid for.

> *Sometimes the agency covers it. Sometimes the aide has to pay for it because what they found is if an agency covers it, then the aide is more likely to leave with like no consequences. And they've just spent the money. So a lot of times they'll ask the aide to pay for it, but then they will, every month they stay there, they will give them X amount of it back. So in the end they've covered it but the aide has kind of put some investment in it as well.*
>
> *—Association representative*

But we received other conflicting reports. One association representative told us that many agencies are offering the training for free and even payment for time in training which helps employees who cannot afford to take time off to take the training or pay for the training itself. Not only does paying for training and the worker's time to train benefit the worker, but the agencies also establish good

rapport with workers, increasing their likeliness that the worker will remain with that agency in the future. A state official added that many agencies give the training for free but absorb the training cost into their business model (i.e., pay for it as an overhead expense), lowering their ability to pay workers a higher wage. As earlier noted, CMS issued a NPRM in May 2023 that would limit agency spending on overhead to no more than 20% of the Medicaid agency hourly reimbursement rate for personal care aide services. If this provision is retained in the final rule, it might become increasingly difficult for agencies to cover aide training as an overhead expense. The CMS NPRM does not consider training as an allowable labor cost because aides are not providing services to Medicaid clients while in training. Some states (e.g., Washington) with training/certification requirements permit aides to work and be paid for providing services to Medicaid recipients before completing training but impose a deadline by which they must successfully fulfill all training/certification requirements. Also, training/testing costs are paid not from provider reimbursement but separately by the state. Since federal Medicaid law and regulations leave training requirements for personal care aides entirely up to states, there is no federal prohibition on using Medicaid funds to pay an aide who is providing services while still training. Moreover, some states allow for many or most training to be completed outside their working hours. This is feasible when most training can be done online and required in-person training can be scheduled for evenings and weekends.

One MCO representative and a state official reported giving out grants or paying for worker training and certification but remarked that workers still may not get paid by the agency during that time. An association representative explained that it is difficult to find a role for the employee in training that warrants paying them for the duration of the training. A state official shared that the price of the training varies widely between a few hundred dollars and almost $1,000. Information found online suggests that training, testing, and certification costs range from $450 to $1,000. Training offered by agencies that plan to offer jobs to successful trainees typically costs less than aide training available from vocational training schools and community colleges, although the latter may charge more because they provide more robust curricula.

3.2.5. New Jersey Nurse Delegation Pilot Project

New Jersey participated in a Nurse Delegation Pilot Project from 2007 to 2011 funded by a grant from the Robert Wood Johnson Foundation. This project allowed nurses at home health agencies to train aides to administer medication to individuals receiving agency-delivered care in their homes (New Jersey DHS, 2011; Anthony et al., 2017). An evaluation of this pilot showed no adverse health effects for consumers, positive impacts on health and quality of life, and satisfaction from all those involved, including nurses, aides, consumers, and agency administrators (Farnham et al., 2011).

The pilot project did not lead to immediate changes in regulatory language (Farnham et al., 2011). However, changes related to delegation in New Jersey's Nurse Practice Act were proposed in 2015, and several were codified in 2016 (New Jersey Board of Consumer Affairs, 2015). These changes allow for nurses to delegate routine tasks such as medication management to aides at their discretion, so long as there is ongoing supervision (Bridges, 2016; Kitchenman, 2015). Additionally, the New Jersey Board of Nursing created a "Delegations of Selected Nursing Tasks Model" which can be used to help nurses decide which tasks could be delegated to a home health aide (New Jersey Board of Nursing, n.d.). A Medicaid billing code that allows agencies to be paid more when delegation occurs was created during the pilot project, but the state did not specify how agencies were to use the enhanced reimbursement. Thus, it is not clear who benefited from the higher reimbursement: the agency, the aide, or the nurse doing the training and supervision. One home care representative shared that agencies could pay workers more to do nurse delegation during the Nurse Delegation pilot project and that this incentive helped with retention at the time; however, the pilot project is no longer active. A state official told us that the billing code created during the pilot project remains available, but other interviewees representing the home health/home care industry were unaware of it and said they had never used it.

One report suggests that nurse delegation is not widely used in New Jersey (Anthony et al., 2017) despite the positive findings from the Nurse Delegation pilot. This could be because home health agencies are not required to delegate nursing tasks, and there is still a significant amount of oversight and supervision required by nurses who choose to delegate tasks to aides (Reinhard, 2001). In addition, aide training is not transferable between clients so aides must be re-trained to work with each new client (Anthony et al., 2017).

Association representatives reported that nurse delegation is still currently available in New Jersey, but that it is rarely used because of the increased costs, time, and energy required to do it with no additional reimbursement. Representatives from one MCO shared that even though they offered enhanced rates, they still could not find an agency willing to use nurse delegation. Additionally, some nurses purportedly perceive it negatively because they would be "putting their license on the line." Whatever enhanced Medicaid reimbursement to agencies for nurse delegation is available does not appear sufficient for agencies to put in the effort to convince nurses that their licenses would not be put at risk if they agree to delegate. A state official shared that when choosing an employment option, applicants for agency aide jobs are more interested in the dollar amount they would earn rather than an increased scope of practice, suggesting that the ability to participate in nurse delegation is not a recruitment incentive -- at least not unless the enhanced agency reimbursement for performing delegated tasks increased the aides' hourly pay. In Washington State and New York, advanced DCW training including nurse delegation does result in higher pay so long as aides are called upon to perform such tasks when providing home care to clients who need this help.

> *[Nurses] themselves needed support, education and assistance with actually figuring out what to delegate, how to delegate and how to oversee delegation because they hadn't been in the situation before. So I think it's extremely variable and really depends upon the leadership of the agency, whether they embrace this idea or not.*
>
> *—Association representative*

Representatives from one MCO requested clarity from the state on what is allowed under nurse delegation and how managed care plans can approach assessment of the service for their members. An association representative similarly requested support, education, and assistance for nurses to help them determine what tasks to delegate and how to conduct oversight. One state official shared that a legislative bill, which has not yet been passed, exists regarding nurse delegation, but there is still much discussion needed on what that service would look like and how it would be implemented.

3.2.6. New Jersey Worker Registry for Self-Directed Programs

CCDE findings noted the importance of creating a formal worker registry to improve recruitment and referrals for people who are willing to work with clients who choose self-directed care (Phillips et al., 2003). The report also noted that New Jersey received a "separate grant that will seek to develop a registry for consumer-directed programs" (Phillips et al., 2003, p. 24). However, the arrangement New Jersey made to subsidize PPP participants' access to Rewarding Work, a multi-state online registry was discontinued and attempts at locating any evaluations or implementation reports for this case study were unsuccessful. Recently, the Collaborative for Citizen Directed Supports New Jersey developed an interactive map for linking consumers with workers (Applied Self Direction, 2023). This registry enables those who join the Collaborative to find workers that are in proximity through a geolocator feature and enables them to filter for specific criteria (e.g., history working with IDD consumers or IDD specific training). Here again, however, no information is available about the effectiveness of

> *[A worker registry] would be beneficial for the program, especially for those handful of individuals that do come into the program and are not yet ready with an identified worker. And so that is something that I think we have the capability to support and, you know, look forward to kind of engaging New Jersey further around what that potentially would look like.*
>
> *—Financial management services*

this registry in matching clients and workers. In theory, Medicaid PCS recipients could access online registries such as Care.com that cater to private payers to locate individual aides who advertise on these sites; however, to do so they would have to pay a fee. Also, such registries appear to be marketing primarily to adult children seeking home care aides for their aging parents and may be less well suited to helping self-directing Medicaid waiver participants and their representatives find aides to assist individuals with IDD.

A few stakeholders commented that state-supported registries could improve consumer access to workers, particularly those with specific caregiving expertise to match the needs of consumers and their family caregivers. One state official confirmed they are working to create an online provider directory through a fiscal intermediary. However, according to one FMS informant, the FMS organization's lawyers are reluctant for the FMS to sponsor a registry because of concerns that this could make the FMS appear to be a third party employer rather than a fiscal/employer agent.

Beyond these formal registry services, one parent of a service recipient commented that within their community they were trying to build a shared resource of available self-directed workers to help efficiently fill gaps in care in the case a worker must cancel suddenly.

3.2.7. Increase the Pipeline of Workers in New Jersey

Multiple stakeholders commented on a variety of options for increasing the pipeline of available home care workers. Some aspects of home care aide work that make these jobs less attractive than other low-paying service jobs are quite difficult to address via Medicaid policy alone. This has led state officials to seek to partner with business and industry groups, philanthropies, and academic institutions. An academic researcher described that Rutgers University has received grants from the New Jersey DHS to improve the pipeline of available workers. Home care association representatives explained that one purpose of the grants is to recruit 250 new home health aides. The grant, whose activities have not yet begun, is further supported by ARP Act funds and would include hiring the workers and offering them a childcare or transportation stipend. Another program created is a home health aide worker scholarship program for high school students who express an interest in health care.

> *We're in the process of building a webpage that will direct people to webpages based on what their interest is, giving them education on the certification process and then also looking at eventually providing information on career pathways. So, you might start out as a personal care worker, but maybe you want to take additional credits or education to become a licensed practical nurse or a registered nurse, et cetera. So, really trying to do more education marketing as well.*
>
> *—State official*

Both a state official and an MCO representative, described similar efforts to increase interest in home care work via vocational technical high school programs where high school students could go through the required home health aide course. The benefits of such a course would include covered certification tuition and needed equipment in addition to receiving course credits toward graduation. Graduates would leave high school fully certified and ready to enter the home care workforce. An association representative commented that programs like this must build awareness, or they may not be used to their full potential.

An academic expert and an association representative also confirmed that there is a current New Jersey legislative bill (NJ 220th Legislature, No. 3141) to have a marketing public awareness campaign to attract more home care workers. In addition, a state employment agency representative shared that the New Jersey Business and Industry Association, which represents 30,000 employers across the state including home care providers, was "desperate for help" with workforce shortages leading to the development of a planned, scheduled event in collaboration with Rutgers University. The in-person event, called Become a Healthcare Hero, was held in Middlesex County and, though over 300 potential job candidates were signed up, only 125 attended.

3.2.8. New Jersey Special Task Force on Recruitment & Retention

In October 2020, New Jersey passed SB 2712, which established a Special Task Force on Direct Care Workforce Retention and Recruitment at the Department of Labor and Workforce Development (Ward et al., 2021). Some of the goals of the task force are to evaluate the effectiveness of retention and recruitment strategies for DCWs in the state and to develop recommendations to help mitigate the issues.

3.2.9. Additional Steps New Jersey Could Take to Improve Recruitment and Retention of Home Care Workers

The stakeholders we spoke to reported several other steps that New Jersey is taking or could take to improve home care worker recruitment and retention.

Address Benefit Cliffs

New Jersey state officials reported being cognizant of benefit cliffs that may affect home care workers. Many home care workers rely on public benefits, such as Medicaid, due to their low wages. Increases in compensation can jeopardize eligibility for such benefits without providing enough resources to replace those benefits through other means (e.g., commercial health insurance). This an example of a benefits cliff.

State representatives reported working on revising the rules around Medicaid eligibility standards, which would allow home care workers to be in less danger of losing their Medicaid benefits based on changes in employment and wages. These changes have not yet been finalized.

Subsidize Transportation

Several stakeholders discussed steps that could be taken to address the transportation issues inherent to home care work. One state representative noted that, due to travel between clients, in many parts of New Jersey it is necessary for workers to own a car or have other reliable transportation. This creates a cost home care workers may be unable to afford. In urban areas there may be costs for parking or for public transportation that are also borne by the home care worker who must travel between the homes of consumers.

Some stakeholders suggested that subsidies or supplemental payments for transportation costs would help with recruitment and retention. One MCO representative reported that a few of the agencies the MCO works with provide transportation for their workers and suggested it would be helpful if more agencies provided this service.

> *Can we provide transportation for people to be able to get to our HCBS members who are in the country on a farm? Can we supplement them somehow on driving/parking? Because in our cities… transportation, parking is very expensive.*
>
> *—State representative*

Provide Full-Time Work to Those Who Want It

One academic researcher noted that a recent survey showed that about 50% of home care workers were not working full-time. A state representative noted that lack of full-time work is one of the biggest complaints the state hears from workers. In conjunction with this, an MCO representative said that it is difficult to find a home care worker for a consumer who qualifies for few hours (e.g., 10 hours per week) because "that's not enough to keep an aide going." The U.S. Department of Labor's "home care rule" that extended Fair Labor Standards Act protections including requiring time-and-a-half hourly wages to be paid to aides that work more than 40 hours per week has unintentionally exacerbated this problem. Reports assessing the national impact of the home care rule found that agencies rarely assigned workers hours for which they would be required to pay overtime and most states (California being the major exception) limited self-directing program participants' workers' hours to 40 per week with no or few hardship exemptions (Doty et al., 2019; GAO, 2020). The reason

is that neither the Medicaid agency reimbursement rates nor the methods for calculating self-directed services budgets provide sufficient funds to cover overtime wages. Accordingly, agencies seldom allow their aides to work hours that would require paying overtime rates. Even when state reimbursement methods would allow for paying overtime, states prefer not to do so in order to control Medicaid costs. (Doty, Squillace, Kako, 2020) Only live-in aides (which in the case of Medicaid service users are mostly family members providing services to self-directed services program participants) are exempt from the overtime pay requirement and that is only if the self-directed program participant is considered to be the worker's sole employer and not a joint employer with the state as is the case, for example, in California and Washington State. The GAO (2020) report found no overall national improvement in home care worker pay following implementation of the FLSA Home Care Rule.

Determining ways to provide full-time work to those home care workers who want it would likely help with recruitment and retention. This would allow workers to earn more and, in some cases, qualify for other benefits such as health insurance.

Increase Respect for Home Care Workers

Finally, several stakeholders suggested that increasing the respect shown to home care workers by the health care industry and society in general would improve recruitment and retention. A state official suggested getting more input from workers and that "sometimes policy needs to come from the bottom to impact the top." Similarly, a parent of a service recipient suggested that the state engage with workers by "finding out what they like about their job, why are they remain at their job, why are they leaving their job."

An association representative suggested the state launch a public relations campaign "that talks about all of the positives of being a home health aide, of being involved in healthcare, and supports people through that choice." Another association representative suggested that home care workers "need to be recognized by their health care counterparts."

4. CONCLUSION

New Jersey's efforts to expand access to HCBS have yielded improvement. However, such progress has likely made recruiting and retaining sufficient home care workers to meet the growth in demand for them even more challenging. Almost two-thirds of those enrolled in a NJ FamilyCare plan were receiving HCBS in 2018, a substantial increase from when the program began (NJ DHS, 2021). Moreover, the Community Care Program and Supports Program has allowed more people living with disabilities to receive services within their communities rather than in institutions (NJ DHS, 2021). The number of people who use self-direction in New Jersey doubled from 2017 to 2020, suggesting successful growth of PPP, which gives qualifying NJ FamilyCare Plan enrollees the ability to hire family, friends, or others as PCAs (NJ DHS, n.d.; NJ DHS, 2021). This shift in services has created more demand for home care workers and may have exacerbated the home care workforce shortage, but New Jersey has used several recommended strategies to address worker recruitment and retention.

Most worker advocates, industry leaders, and academic experts recommend improving compensation for home care workers. New Jersey has taken several steps to improve DCW compensation. The state is also working to increase the minimum wage for all workers to $15 by 2024. Stakeholders reported that the minimum wage increase created more competition for workers and caused many home care workers to leave the field for jobs in the retail and service industries. In response, the state used FMAP increases to increase self-direction budgets and rates to agencies. And the state has used budget appropriations over the past five years to improve wages for home care workers. Research will be needed to determine if these funds have helped increase worker wages.

Training is another recommended strategy for improving home care worker recruitment and retention. New Jersey has implemented training requirements for various types of home care workers, requiring 76 hours of training for CHHAs and providing continuing education for DSPs. Stakeholders said that administrative delays between the time workers receive training and become officially certified to work (e.g., upwards of 6-7 weeks) result in some workers finding other permanent employment between their training and certification and never beginning work in home care. This was noted as a key barrier to home care worker recruitment. Requiring applicants for home care aide jobs to pay out-of-pocket for mandatory pre-employment CHHA training may increasingly pose an affordability barrier that makes home care aide jobs less competitive in relation to other low-income service jobs that provide on-the-job training.

New Jersey has also sought to encourage agencies to implement nurse delegation, which allows a nurse to train and supervise aides to provide routine skilled tasks. This is expected to increase DCW satisfaction by increasing their scope of work and level of responsibility. However, one report suggests that nurse delegation is not widely used in New Jersey (Anthony et al., 2017). Stakeholders agreed and suggested that this is because agencies are not being reimbursed or not enough for the extra effort involved in training and supervising aides or the effort managers would need to expend to overcome nurse resistance to delegation. Some interviewees said that despite Board of Nursing assurances that they will not be penalized so long as they follow prescribed training protocols, many nurses are fearful of losing their licenses due to mistakes made by aides they have trained.

The stakeholders we spoke to reported other efforts that are underway or being planned to improve recruitment and retention of home care workers in New Jersey including:

- An IDD consumer group has developed a worker registry for consumer-directed programs. And other stakeholders reported pursuing a statewide registry that would help match consumers with workers.

- Rutgers University has received a grant to increase the pipeline of home care workers. This will include scholarships for worker training and stipends for related costs, such as childcare.

- The New Jersey Business and Industry Association is partnering with the New Jersey Department of Labor to increase recruitment of home care workers. This effort, entitled Become a Healthcare Hero, will include job fairs and marketing efforts.

- The state is working on changing Medicaid eligibility requirements, so that home care workers do not lose benefits due to increased compensation.

- A marketing campaign to improve respect for home care workers and attract people to this field is being discussed.

- A special task force on recruitment and retention is addressing additional challenges. These may include ways to ensure full-time work for those who want it and help with covering home care worker transportation costs.

Despite these efforts, recent data suggest that New Jersey continues to experience workforce shortages and has seen a reduction in the HCBS workforce since 2017 (NJCCN, 2022). The number of home health aides in New Jersey dropped from 60,343 in 2017 to 50,416 in 2021, representing a 16.5% decrease (NJCCN, 2022). Only time will tell if this was a temporary drop and numbers of CHHAs will rebound post-pandemic. Additional research will be needed to determine if current efforts will have a lasting effect on home care worker recruitment and retention.

This New Jersey case study provides insights into the daunting challenges states face in seeking to address the home care worker shortage, which has become more acute as New Jersey and other states have striven to "re-balance" Medicaid LTSS use and spending away from institutional care toward HCBS. In a tight labor market, the key to overcoming the home care workforce shortage is to ensure that home care aide jobs can compete with other entry-level jobs and to expand the labor pool from which home care workers can be recruited to the extent possible.

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ACRONYMS

ARP	American Rescue Plan act
BIP	Balancing Incentive Program
CCDE	Cash & Counseling Demonstration and Evaluation
CFC	Community First Choice
CHHA	Certified Homemaker/Home Health Aide
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nursing Assistant
COVID-19	Novel Coronavirus
CPR	Cardiopulmonary Resuscitation
DCW	Direct Care Worker
DSP	Direct Support Professional
EVV	Electronic Visit Verification
FMAP	Federal Medical Assistance Percentages
FMS	Financial Management Services
FY	Fiscal Year
HCBS	Home and Community-Based Services
IDD	Individuals with Developmental Disabilities
LPN	Licensed Practical Nurse
LTSS	Long-Term Services and Supports
MACPAC	Medicaid and CHIP Payment and Access Commission
MCO	Managed Care Organization
MFP	Money Follows the Person
MLTSS	Managed LTSS
MPR	Mathematica Policy Research
NADSP	National Alliance for Direct Support Professionals
NC NOVA	North Carolina New Organizational Vision Award
NCSL	National Conference of State Legislatures
NJ DHS/DDD	New Jersey Department of Human Services, Division of Developmental Disabilities
NJ DHS/DDS	New Jersey Department of Human Services, Division of Disability Services
NJ DMAHS	New Jersey, Department of Human Services, Division of Medical Assistance and Health Services
NJCCN	New Jersey Collaborating Center for Nursing
NPRM	Notice of Proposed Rulemaking
PAS	Personal Assistance Services
PCA	Personal Care Assistant
PCS	Personal Care Services
PHE	Public Health Emergency

PPP	Personal Preference Program
RN	Registered Nurse
SDE	Self-Directed Employee
VBP	Value-Based Purchasing
WPT	Wage Pass-Through

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